Postgraduate General Practice Training in the United Kingdom

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The structure of general practice postgraduate training in the United Kingdom provides a dramatic contrast with family medicine residency training the the United States. Mandated by law, postgraduate training in general practice became compulsory in 1982. All new general practitioners working for the National Health Service (the overwhelming majority of general practitioners) must successfully complete a three-year Vocational Training Scheme (VTS). This scheme occurs after medical school and following a compulsory "preregistration" year (similar to an internship), which consists of two independent rotations of six months each in general medicine and general surgery. Following that, physicians (trainees) who enter general practice (approximately one half of all medical school graduates) take their VTS either through a self-constructed scheme (put together by the trainee) or an integrated scheme (a formal scheme put together and under the auspices of a hospital, medical school, or other institution). In all instances, the Joint Committee on Postgraduate Training for General Practice is the national body that has overall responsibility for all of the vocational training schemes.

The three-year general practice training program consists of two years of hospital work, one year of which must contain two rotations of six months each chosen from the following list: (1) emergency room or general surgery, (2) general medicine, (3) geriatrics, (4) obstetrics and gynecology, (5) pediatrics, and (6) psychiatry. While the second year of hospital training can occur in any hospital post, most trainees choose to do the two additional six-month rotations from the above list (for a total of four of the six rotations).

The third and final year of vocational training occurs in a preceptor-like fashion in a practicing general practitioner's (trainer's) office. Currently trainers are selected by a fairly rigorous process (using criteria such as desire, ability, time, clinical competence, practice organization, and so on), and only 10 percent of practicing general practitioners (approximately 2,000) are trainers. These trainers must attend training courses to learn and practice teaching methods, and they have periodic training workshops with other trainers. They are also paid for their teaching. Trainees have only one trainer (although they may work with the trainer's partners to varying degrees), and each trainer has only one trainee per year. In fact, this one-to-one trainer-trainee relationship is an important aspect of the VTS.

In addition to the time spent seeing patients in the trainer's office, which is the main activity of the trainee year, there is also formal teaching time set aside on a weekly basis. While the amount of this structured teaching time varies from practice to practice, the median teaching time is one to four hours each week (in addition to patient-related problems as they come up, ie, hallway questions). While a wide variety of educational methods are used in teaching, the following methods are those most commonly utilized (in over one half of the training sites)[1]:

1. Problem case discussions (initiated by the trainee about cases with which he or she has problems)
2. One-to-one tutorials (in-depth prepared discussions of a specific topic given by the trainee)
3. Trainee sits in on trainer's office hours (observational)
4. Random case discussions (trainee discusses cases he has seen during the week, which are chosen at random by the trainer)
5. Joint home visits

Throughout the entire three-year VTS, trainees also attend a "day release course" for one half-day per week. Topics covered during this time include a wide range of general practice areas, with the most common (occurring in over one half of courses) being the structure of general practice services, the health visitor, the district nurse, the social worker, the certifying exam-

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ination of the Royal College of General Practitioners (ie, "the boards"), prescribing therapy, medical and legal issues, finances, medical records, old age, family planning, psychosexual difficulties, child development and assessment, skin disorders, and eye disorders.[2]

At each level of the VTS, there exists an administrative structure to ensure that the system works. Each trainer is responsible to a course organizer, who in turn is responsible to a regional general practitioner advisor, who reports to a postgraduate dean for a specific geographical area. This structure, despite its permutation of lettered organizations (eg, CPME, JCPTGP, GMSC, RCGP, etc), appears to work reasonably well.

In light of the fact that most general practitioners in the United Kingdom do not care for any hospitalized patients (these are cared for almost entirely by hospital-based consultant physicians in all other specialties), it is of particular interest that the VTS contains two years of hospital-based training after the hospital-based preregistration year. Actual training in general practice, therefore, occurs only during the one half-day release course (10 percent of the first two years) and the entire third year; this training occupies only 30 percent of the time involved during the four years of postgraduate training. Additional weaknesses in the VTS, as compared with the family practice training programs in the United States, would also seem to include the following:

1. Little control over hospital training by the VTS (ie, the first two years consist of four independent "jobs," as opposed to a comprehensive program)
2. A lack of three years of continuity in general practice clinical activities (ie, trainees spend only one year seeing general practice patients)
3. A minimal amount of didactic teaching on clinically oriented general practice topics
4. A lack of clinical general practice occurring with peers
5. The potential variability in the quality of the trainers (since the trainer represents the only general practitioner clinical teacher for each trainee).

On the other hand, the site of training, the physician's office (which represents more of a "real world" experience), the emphasis on behavioral, social, health care delivery, and practice management topics, and the strong one-to-one relationship that develops during the year between the trainer and trainee have positive advantages and offer a unique contrast to the family practice center in the United States.

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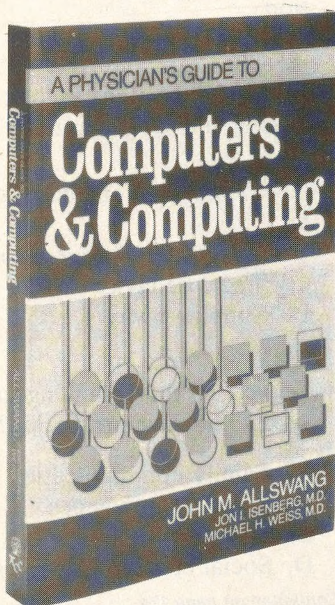

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